

Form HS-31-A	ARKANSAS WORKERS' COMPENSATION COMMISSION	HS-31-A
Ark. Code Ann. §11-9-409 & AWCC Rule 31 Rev. 1-1-2008	HEALTH & SAFETY DIVISION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

Application for (check all that apply)

Approved Professional Safety Source (APSS) **Field Safety Representative (FSR)**

(Note: Attendance at an on-site AWCC class is mandatory for APSS certification)

Section 1. Personal Information

1) Name (include all names referenced in submitted materials): Last: _____ First: _____ MI: _____	2) Telephone no.: Primary: (_____) _____ Secondary: (_____) _____	3) Social Security no.: _____ 4) Total no. of years occupational health and safety experience : _____
5) Mailing address: _____	6) City: _____	7) State: _____ 8) Zip: _____
9) E-Mail address: _____		

Section 2. Professional Certifications

Check all that apply. Enclose copy of current membership card. Information will be verified.

Certification	Certificate No.	State (if applicable)
<input type="checkbox"/> Certified Safety Professional (CSP)		
<input type="checkbox"/> Certified Industrial Hygienist (CIH)		
<input type="checkbox"/> WSO Certification (specify Certified Safety Manager or Certified Safety Specialist)		

Section 3. Education and Professional Training Note: A certified transcript must be sent **directly from the granting institution** to the Arkansas Workers' Compensation Commission, Health and Safety Division, P.O. Box 950, Little Rock, AR 72203-0950, ATTN: FSR/APSS.

<i>College or University</i>	<i>City, State</i>	<i>Attendance Dates (From/To)</i>	<i>Sem. Hrs. Completed</i>	<i>Major</i>	<i>Degree Earned</i>

Section 4. Occupational Safety and Health Professional Experience Using Attachment 1, list each occupational health and safety work assignment in chronological order, beginning with present position.

Section 5. Signature

I certify that the preceding statements, including attachments, are accurate to the best of my knowledge, and authorize the Arkansas Workers' Compensation Commission to verify the information. I understand that any falsification of information in this application, including attachments, may be cause for rejection or withdrawal of the Field Safety Representative and/or Approved Professional Safety Source designation.

Applicant Signature: _____ Date: _____

(please use ink)

Occupational Safety and Health Work Experience

Use a separate copy of Attachment 1 for each change in position, regardless of whether or not there was a change in employers.

1) Name during employment:	2) Position with this employer::
3) Employer: Name Telephone no.: ()	
Address:	
City:	State: Zip:
4) Employment dates (Mo/Yr.): From: ___/___/___ To: ___/___/___	5) Major product or service of this company:
6) Immediate supervisor: Name Telephone No.: ()	
7) Description of occupational health and safety work experience. Indicate the percentage of your time spent in the following areas:	
<input type="checkbox"/> Hazard identification <input type="checkbox"/> Hazard evaluation <input type="checkbox"/> Hazard control design <input type="checkbox"/> Environmental	<input type="checkbox"/> Safety & health program design <input type="checkbox"/> Safety & health program evaluation <input type="checkbox"/> Safety & health communication <input type="checkbox"/> Incident investigation
<input type="checkbox"/> Safety training & education <input type="checkbox"/> Supervision of other health & safety professionals <input type="checkbox"/> Neither health & safety or environmental <input type="checkbox"/> Hazard control verification	
For the three (3) areas above where you spent the most time, provide a brief description of your work in those areas:	